VICTIMS OF WAR IN SRI LANKA:
A Quest for Health consensus

Manning Hall
University of London Union
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Abstracts

INTERNATIONAL CONFERENCE ON HEALTH

VICTIMS OF WAR IN SRI LANKA: A Quest for Health Consensus

HEALTH STATUS OF REFUGEES IN TAMIL NADU

by

Karunyan Arulanantham MD, FAAP, FACE

There are currently between 70,000 to 80,000 Tamil Refugees living in about 125 camps. Another 100,000 refugees are estimated to be living outside the camps. The following data pertains only to those living in the camps.

Most camps are situated away from centres of population. Tents, temporary sheds and disused buildings are used to house these refugees. Bore wells are a common source of water supply. Toilet facilities are inadequate or non-existent.

Nutritional diseases

Under nutrition as manifested by low weight and impaired growth of children is widespread. In a study of 250 children at age of school entry over 80% of the children were below the 5% when plotted on the growth charts of the National Council of Health Statistics - the WHO approved statistics. This Caloric undernutrition is to be expected as the allowance given by the Indian Government is sufficient to purchase only around 70% of the caloric needs of a family.

Vitamin deficiency is also very widespread and is manifested as night blindness and Bitot's spots. It is estimated to affect up to 30% of the child population.

Other illnesses

As would be expected from the poor housing, sanitation and the nutritional status of the refugee population, gastrointestinal infections are the commonest illness, followed by respiratory infections. Typhoid, Malaria and Tuberculosis are endemic. Chorea is a problem during epidemics. Worm infestations are also very common.

Dental caries are very common and is estimated to affect up to 40% of the population. Over 70% of the population are anaemic. Diabetes, hypertension, heart disease and gastroesophagael reflux diseases are also commonly seen.

In a study of 250 children at the age of school entry 13.7% were found to have refractory errors, 3.7% had chronic ear discharge, and 2.8% had asthma.

Mental Health

Post traumatic stress disorder, depression and anxiety disorders are seen very commonly. While precise numbers are now known incidents of suicides seem to be higher than would be expected in a non-refugee population. Many of the suicides seem to be the result of impulsive acts after associated with family disputes. Alcoholism is widespread.

Family Planning

Family planning services are not available to the refugees. However, statistics of child population seem to point towards shrinking population growth. Instances of voluntary sterilisation of nuliparas females unwilling to bear children in the current refugee situation have been recorded.

Access to Acute Services

Acute medical services are available without cost to the refugees through the hospitals in Tamil Nadu. Problems of access are due to the remote locations of the camp and the non-availability of transportation.

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VICTIMS OF WAR IN SRI LANKA:A Quest for Health Consensus

RESPONDING TO HEALTH AND CARE NEEDS:

Institutional Role and Challenges

by

Karunyan Arulanantham MD FAAP FACE

The task of meeting the health care needs of the "Victims of War" in Sri Lanka is an enormous one. Institutions and organisations responding to these needs include the government of Sri Lanka and many non governmental organisations.

The problem of the individual victim of the war is caused by a combination of economic, health, psychological and spiritual factors. Organisations too have economic, political and organisational problems in responding to these massive needs.

The tasks of the institutions is to assist in the empowerment of individuals and communities to solve their problems by providing appropriate assistance and by working towards the creation of an environment conducive to problem solving with dignity. The accomplishment of this task will require overcoming many barriers including working in an adverse political climate and with inefficient organisational structures. New ideas and innovative programmes are needed for more effective problem solving. Expatriate Tamils and Tamil organisation have a special role to play in this situation because of the their strategic position in the west and their ability to understand the ground situation as well as the requirements of the western donor organisation. The Tamil organisations have to overcome problems of weak organisational structure and lack of faith and vision. If the expatriate Tamil organisations can overcome these problems and develop effective programs they have an opportunity to play a historic role in restoring health to the victims of war in Sri Lanka.

THE EXPERIENCE AND IMPRESSIONS OF AN AMERICAN PAEDIATRICIAN IN SRI LANKS

DR. JERRY S. EHRLICH, MD

Paediatrician, New Jersey, USA

Jerry S. Ehrlich, M.D. is a Board Certified Paediatrician in the United States with twenty-eight years experience in private and academic medicine. As a volunteer for Doctors without Borders spend over four months at General Hospital Batticaloa. He provided the only specialised Paediatric care for the area which included 400,000 people and sixteen refugee camps. In addition to patient care, Dr. Ehrlich was also responsible for the training of two Sri Lankan Interns in paediatric medicine.

A slide presentation with commentary will portray the difficult and inadequate conditions under which children were cared for.

The overcrowding, poor sanitation, lack of running water and electricity shortages or total unavailability of necessary drugs and intraveneous fluids were some of the problems he encountered. The military occupation further complicated access to medical care. Diseases that occur rarely were part of everyday living in Sri Lanka. These condition contributed to excessive morbidity and mortality in these children.

A handout showing a typical month's admissions will be distributed. Time will be allotted for a question and answer period.

Upon his return to the United States Dr. Ehrlich felt the public should be made aware of this tragic situation. His son-in-law and a professional cinematographer travelled to Sri Lanka and interviewed many children. From these interviews a documentary video has been completed. Rice and Money - The Effects of War and Povery on Children in Sri Lanka is available here for your viewing.

Diagnosis of those who Died

1. Severe Dysentery badly dehydrated and in electrolyte imbalance.
2. Neo-natal Asphyxia with birth trauma.
3. Kwashiorkor/Vit A deficiency with secondary infection.
4. Prematurity/Respiratory failure.
5. Small premature infant (850 grams).
6. 3 months old bilateral pneumonia/arrived critical.
7. 10 months old, fever, fits, drowsy became progressively unresponsive - respiratory arrest ? encephalitis.
8. 7 years ? snake bite arrived lethargic. Given ASV became progressively unresponsive - respiratory arrest.
9. 11 day old arrived (Wt. 1 kg) emanciated/moribund.
10. 7 months old transferred from peripheral hospital, unresponsive in severe respiratory distress (bilateral pneumonia.
11. 1½ years transferred from peripheral hospital with fever, fits, semi-comatose. LP - normal. Treated with antibiotics. Died 18 hours after admission - ? encephalitis.

Diagnosis of those who were transferred:

1. Encephalitis - left with residual neurological impairment - to Neurologist.
2. One month old with probable Hirschsprungs disease (biopsy report not available).
3. Muscular dystrophy.
4. Cystic Mygroma.
5. 2 year old with mass in the thigh (referred for biopsy).
6. Persistent (6 mths) discharging ear with perforation - for further management.
7. Persistent (7 mths) discharging ear - Cholesteatoma.

BATTICALOA GENERAL HOSPITAL

MONTHLY REPORT DECEMBER 1991

PAEDIATRIC WARD

TOTAL NUMBER OF ADDMISSIONS: 349 + PBU 16 = 365

WARD 2: 236

WARD 6: 113

PBU: 16

SEX:

MALE: 184

FEMALE: 165

AGE:

UNDER 2 MONTHS OLD: 16

2 MONTHS TO 2 YEARS OLD: 198

2 YEARS TO 10 YEARS OLD: 109

OLDER THAN 10 YEARS OLD: 26

AVERAGE DURATION OF HOSPITALISATION: 46

NUMBER OF DEATHS: WARD 2: 6 WARD 6: 1 PBU: 4

NUMBER OF TRANSFER: 7

NUMBER OF OUTPATIENT CONSULTATIONS: 218

DIAGNOSIS:

GASTROINTESTINAL DISEASE:	99
RESPIRATORY TRACT DISEASE:	48
MALARIA:	50
NERVOUS SYSTEM DISEASES:	29
UROLOGY AND RENAL DISORDERS:	15
CIRCULATORY SYSTEM DISORDERS:	11
FEVER (VIRAL)	23
INFECTIOUS DISEASES:	13
INTOXICATION:	10
OTHERS:	61
TOTAL:	349

DIAGNOSIS (IN DETAILS)

RESPIRATORY SYSTEM*

BRONCHIOLITIS:	4
OTHER LOWER RESP. INFECTIONS	27
ASTHMA:	10
PERTUSSIS:	2
OTHERS:	5

GASTROINTESTINAL:

DYSENTERY:	24
DIARRHOEA:	64
HEPATITIS:	11
OTHERS:	

CIRCULATORY SYSTEM:

CONGENITAL HEART DISEASE:	5
RHEUMATIC FEVER:	1
HEART FAILURE:	
SEVERE IRON DEFICIENCY ANAEMIA:	1
THALASEMIA:	3
RHEUMATOID ARTHRITIS:	1
OTHERS:	

Workshop V
Health of Displaced People and Refugees

Dr. Jeya Henry
Head of Food Science and Nutrition
Oxford Brookes University
Oxford, UK.

Large scale displacement of populations across national and international boundaries has now become a common place phenomenon. In most instances, such population movements have been associated with high levels of morbidity and mortality, particularly during the early phase of displacement. This may be due to a variety of reasons. These include poor sanitation, malnutrition, inadequate shelter, clothing, water and food. In addition, insufficient or improper use of scarce health resources may exacerbate the situation.

Despite many years of international relief, there is a glaring gap in our overall understanding of how best to efficiently provide relief operations to this vulnerable group. An example of this is the nutrition related morbidity and mortality that has been reported from many refugee camps around the world. These include the outbreak of pellagra, scurvy and beri-beri due to the provision of refugee rations that were inadequate in vitamins. This workshop will therefore address the major issues that relate to the increased risks of morbidity and mortality, and outline proposals that would enable displaced peoples to have adequate access to proper food, clean water, sanitation, medical services and shelter.

INTERNATIONAL CONFERENCE ON HEALTH

VICTIMS OF WAR IN SRI LANKA: A Quest for Health Consensus

WORKSHOP:Public Health and Communicable Diseases

by

Dr R Jayaratnam,

Consultant in Public Health Medicine, East London & City Health Authority, London

ABSTRACT

North & East of Sri Lanka with a population of about 2.2 million has had its health service structure mainly the primary health care system disrupted by the ethnic conflict. There is shortage of man (& woman) power, shortage of resources and increasing illness. These illnesses include the 'normal' illnesses, those due to environmental derangement (lack of sanitation, poor hygiene, pollution etc.), illnesses due to physical & mental trauma and others. Sophiscated research is not essential at this stage as we have sufficient information which could be collated; however some research needs to be done on specific issues.

Some special groups which need immediate attention are Women (General Health, Under - and Malnutrition, Proper planned ante-natal & post-natal care); Children (General Health, Under- and Malnutrition, Immunisation, Surveillance, Infections, Skin Diseases, Accidents and Injuries); Elderly (General Health, Malnutrition, Vision, Hearing, Mobility, Isolation). Dental care is important in all groups.

Possible Solutions: Health programmes should reach all sections of the community esp. those living in rural areas. Highly trained physicians cannot be provided to cover all the periphery. Hence we need to build up the primary health care system along with a massive health education component. Family Health Workers should provide the basic health care with support from doctors, para-medics et el. Public Health Engineering should play a major role in improving the conditions required to improve public health. Administrative control of the public health service should be local. The people should be 'educated' to look after their health.

All this has potential resource implications. Training is another key component. And finally health care programmes should be linked to other programmes.

Mr N.KANDASAMY
Co-ordinator,Human Rights Desk,Movement for Inter Racial Justice and Equality,Sri Lanka

HEALTH STATUS OF TORTURE SURVIVORS

The section is based on personal communication with the Medical Officer (MO) attached to the Family Rehabilitation Centre (FRC) in Colombo.

FRC is a non-government organisation caring for victims of violence due to socio-political upheaval, irrespective of race, caste or creed. It is an apolitical organisation.

Victims of violence include:

1. Torture Survivors (TS)
2. Family members of TS
3. Widows of war
4. Children of war
5. Displaced persons living in welfare centres and outside.

Since 1991 M.O. had seen over 600 TS. They include all communities in Sri Lanka and tortured by all armed groups, both state and militant organisations.

The health status of TS depends on:

1. The types of torture
2. Duration of torture
3. Time lapse between torture and medical examination
4. Psycho-social prospects after release
5. Age groups and other demographic features of TS

1. DEMOGRAPHIC FEATURES OF THOSE SEEN AT FRC

1.1 Age - All age groups
youngest 17 years
oldest 62 years
Most in 20 - 30 yr age group

1.2 Sex
Mostly males
Few females

1.3 Ethnic group
Mainly Sinhalese (1987-89) and Tamils (1990 -)

1.4 Occupation - mostly unemployed or self-employed

2. TYPES OF TORTURE

2.1 Bondage with rope - hands and feet

2.2 Blind folding

2.3 Assault with blunt objects
- gunbutt, batton, S-lon pipe filled with cement

2.3.1 Parts of body assaulted
A. soles of feet -
B. joints
C. chest, back
D. head - direct or after placing book or putting on a helmet - force spread over large area

2.4 Hanging

2.4.1 Hung by thumbs
2.4.2 Hung by feet
This is followed by `submarino'

2.5 Submarino

2.5.1 Dry - shopping bag placed over head and tied around neck suffocation sometimes introduced chillie/pepper powder

2.5.2 Wet - Head lowered into containers having water - mostly polluted

This is continued, to the point of suffocation. Aspiration is possible.

2.6 "Dharma Chakra" - hands and feet tied together, a pole passed between tied limbs and trunk. The ends of poles placed on edges of two tables. The TS is rotated and beaten all over body.

2.7 Sexual assault
Beating the genitalia, thrusting bottel, objects into vagina (in few cases). Young boys repeatedly masturbated.

2.8 Made to witness:

2.8.1 Killings
2.8.2 Torture

2.9 Slapping - "telefono" - across the ears

2.10 Burns - with lighted cigarette

2.11 Pricking - under nails

3. **DURATION OF TORTURE**

Ranged between to few hours to weeks (3)
average 5 days
Done in sessions, average 3 hours

4. TIME LAPSE BETWEEN TORTURE AND MEDICAL EXAMINATION

Ranged between 3 months and 5 years
average 3 years

5. PSYCHO-SOCIAL PROSPECTS FOR FUTURE

5.1 Support from family, relations, friends
5.2 Attitude of fellow villagers towards TS
5.3 Marital harmony/problems
5.4 Socio-economic status
    5.4.1 Employment prospects
    5.4.2 Continuing education
5.5 Threat of re-arrest, torture and death on return to former residence

PRESENTING COMPLAINTS AT TIME OF MEDICAL EXAMINATION

01. Chronic headache
02. Loss of weight
03. Sleep disturbance
04. Night mares
05. Poor appetite
06. Chest pain
07. Back ache
08. Pain in soles when walking
09. Joint pains
10. Lifelessness
11. Depressed
12. Irritated and annoyed easily
13. Low sexual drive
14. Poor vision
15. Skin problems - scabies, fungal infections

APPROACHES AT FRC

1. Medical screening and management
2. Counselling
3. Physiotherapy/Relaxation therapy
4. Referral for socio-economic, self-employment and legal services.
5. Skill training for self-employment

RECOVERY

Very slow

PROBLEMS

Dependency created

International Humanitarian Law and the Right to Health: The Civilian Population during Armed Conflict

David Kausman MRCP, Medical Coordinator, Amnesty International

International humanitarian law is embodied in the Four Geneva Conventions of 1949 and the Two Additional Protocols of 1977. These international instruments approach the question of civilian health during armed conflict not from the perspective of the population's *right* to health, but from the perspective of the state's *obligation* to ensure the provision of medical services. They distinguish between international armed conflict and internal armed conflict. For *international armed conflict*, the Conventions and Additional Protocols set out a robust system designed to ensure protection and care for the civilian sick and wounded, protection for institutions at which treatment is given and for the personnel who deliver it, and an adequate level of medical services for the civilian population even under conditions of foreign occupation. They include firm measures for enforcement of these standards. However, although an attempt is made to reproduce these standards in dealing with *internal armed conflict*, the Conventions and Additional Protocols are greatly weakened in this case by a fear of conferring legitimacy on armed opposition groups. When setting out standards for provision of civilian medical care in internal armed conflict, the Conventions and Additional Protocols lack precise definitions, fail to name specifically those who are answerable for the obligations they set out, do not include any enforcement provisions, and leave open to dispute the very question of the distinction between armed internal conflict and other forms of violence within a state. As a result, they are open to selective interpretation, and risk leaving the health rights of civilian populations without the protection of international humanitarian law during internal conflict. Given the increasing prevalence of internal armed conflict, which is far more common that international conflict in the post Cold War world, this is a serious deficiency in international humanitarian law.

Abstract of Paper read at the Conference on "Victims of War in Sri Lanka A quest for Health Consensus"
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University Of London Union, London.

CURRENT PATTERN OF HEALTH CARE AND RESOURCE ALLOCATION

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North East Province extends over an area of 18,347 sq. kilometers of Sri Lanka. The seven districts of North East Province are described in terms of its extent and population. The percentage of the respective population and land mass in North East Province is given in brackets (Annexure 1). As it could be observed Jaffna district alone has 34% of the population of N.E.P. in a land area of 7.4% of the province. On the other hand Mullaitivu, Vavuniya and Mannar are sparsely populated. Hence the demand, need and provision of Health services differ within the Northern part of the province in terms of quality and quantity; in the Southern part of the North East province (former Eastern Province), population distribution is more concentrated on ethnic grounds and services provided differ accordingly.

Over the years since the "Language only act" of 1956 there had been a gradual decrease in the number of personnel admitted for training in the many varying disciplines of health services. This has resulted often in lesser number of Tamil speaking persons being taken for training. This is seen among the paramedical staff, their age pattern, mean age in the various categories being past 50 years (Annexure 8). This situation further deteroriated when the training itself is conducted only in Sinhala medium. Unless a person has more than a working knowledge in Sinhala - the technical terminology, ability to communicate with the rural public especially in the field training programmes (eg. Public Health Inspectors, Tutors) - the Tamil candidates found it difficult to complete the course. Further some programmes for promotional aspects (Nursing officers to sisters) are also conducted in Sinhala which dissuades Tamil speaking personnel to participate.

There are two schools for Basic Nursing in N.E.P. - one in Jaffna and one in Batticaloa, which are the only two institutions to which Tamil speaking nursing and midwifery students are admitted. These schools often go on without any new student being admitted for years while the schools in the other regions of Sri Lanka continue to admit students annually and proceed with regular teaching and training programmes. Even for the Tamil nursing personnel who have been employed, further promotional aspects are limited as the only post basic training institute in Colombo is teaching in Sinhala medium as mentioned above. Thus, there is a very acute shortage of midwives, staff nurses, nursing sisters and tutors in N.E.P. (Annexure 3, 4).

Even routine functioning has been disrupted by poor allocation of funds for recurrent (Annexure 7) expenditure, refusal to allow movement of equipments, spares, chemicals and drugs to N.E.P., all in all, increasing the frustration and determination of staff, yet limiting the quality and quantity of service.

Even transport to Colombo, of patients who cannot be adequately treated in Jaffna (eg. for Radiotherapy) has become very difficult. I.C.R.C. after three years has graciously brought a ferry to transport patients from Point Pedro to Trincomalee and from Trinco patients are taken by bus to Colombo, the journey from G.H.T. Jaffna to Colombo takes around 30 hours.

Within the area there are limitations in all forms of transport except bicycles which is not suitable for urgent acutely ill patients; vehicle allocations to Tamil speaking areas were limited by the government for decades. Even G.H.T. Jaffna for many years, had only one running ambulance at any one time. Even most of what was made available in 1987, to the institutions in N.E.P. were taken over by the military personnel of government and anti-government forces.

Some medical institutions have been demolished; some are too close to military establishments and going for medical attention is more riskier than the continuing illness; in some areas the people including staff have left the area, when the military moved in leaving the elderly and infirm behind.

Further, lack of other infrastructure facilities - light, electricity, fuel, water, telephone, transport delays has added to the higher rates of infections, increasing the morbidity and mortality patterns.

The private practitioners, Siddha and other physicians, illegal and unlicensed druggists play an significant role in todays situation, as they are unable to break the military embargo adequately to function effectively.

There are five private hospitals with a total bed strength of 123, and 119 private dispensaries providing western type of treatment in Jaffna. The average attendance has dropped by 70% during the last two-three years. The reasons given are:-

1. Transport difficulties, making it very difficult to reach the earlier "family doctor" or a private hospital.

2. Exorhitant cost of treatment in the private hospitals and dispensaries which have to buy the drugs in the "Black market" at 3 to 10 times the price. One example of "Black marketeering" is the packet of Family Planning tablets - oral contraceptives - which usually costs Rs.1.50 for three month supply was sold at Rs.50/-

Fortunately this situation does not arise with regard to medical under graduate training, which is not in the hands of the Health department. But here too subtle changes have been brought about by allocating seats in the University for backward areas.

Though we see a gradual deterioration in the health services since fifties and sixties, in the North East Province compared to the rest of the country in terms of Personnel, Equipments, Facilities and Monetary Allocations, in the field of medical education, one factor - it being outside the health department - viz Universities, continued to produce graduates, who after post graduate education locally and training abroad continued to strengthen the health services in N.E.P. till 1983 (Annexure 5). In 1983 communal violence of an unprecedented scale, with military precision, shook the country, drove Tamils to the North East and abroad.

The military atrocities in the N.E.P. during the after math of the 83 violence, irrespective of person and position resulted in youngsters being attracted to militant movements against the government on the one hand; grown ups saw no future, for themselves and their children in terms of peace, studies, employment and comfort and began to leave the country on the other. Thus the medical personnel too, including the specialists who were holding the fort for Health services, began to leave the N.E.P., clinical medicine taking the biggest blow both in Hospitals & University. When the leaders in the community left, the others followed suit. Since 1983 the health services deteriorated dramatically and after 10 years we are in the lowest ebb probably what we may have been 75 years ago, when there was one provincial colonial surgeon for the province, doing all forms of surgery from Head to Foot (Annexure 6).

The shortage of consultant staff hampers the undergraduate training partly and post graduate training fully. The expectation of a young doctor in terms of academic improvement, psychological and social recognition, physical facilities provided, apparently are not satisfied by the present situation in the N.E.P. Hence we note young medical graduates applying for posts mostly outside the N.E.P. To date, only two fully qualified specialists have returned to the N.E.P. Since the beginning of the exodus of 1983, that too one to Trincomalee (1993) and one to Vavuniya (1994). We earnestly hope this would set a new trend of returning "home".

Monetary allocations for Buildings Equipments and other development in the form of capital expenditure is minimal to N.E.P. Even the donations by British Government authorised in 1987 find it difficult to reach Jaffna - even now in 1994 some are still on their way. The MIOT donation of 1990 has not got out of the port of Colombo as yet.

3. Even in the black market for months common drugs are not available due to the embargo on transport of drugs to the North.

On a test day 25.8.94 the following common drugs

- Inj. Crystalline Penicillin
- Prochlorperazine tablets
- Vitamin B complex tablets
- Contrimoxazole tablets
- Aludrox tablets
- Aminophylline tablets
- Prednisolone tablets

were not available in the larger drug stores in Jaffna town.

Since drugs, though in short supply were still available in Government hospitals and free and since most patients also had much free time now started to go to Government hospitals. The earlier attendance in the O.P.D. used to be 8 visits per person per year. In 1993, total visits to the O.P.D. in all government institutions of N.E.P. (still surviving) accounted to 2,281,317 giving an average of 2.6 visits per person per year instead of the expected two visits.

The unfortnate public of N.E.P. will be thankful to the SCF (UK) and UNICEF which have got involved in directly, in training and paying for two new category of personnel - Rural Health Assistants (R.H.A.) and Health Visitors (H.V.) - who in a limited manner provide Primary Health Care, in rural and urban slum areas, as substitute Public Health Midwives and Public Health Inspectors and thereby preventing a complete break down of Community Health Activities. Also the M.S.F. (France) in providing limited specialist services in B.H. Point Pedro, Trincomalee, G.H. Batticaloa helped to run the hospitals with some specialised services, and the team of Cuban Doctors in Amparai did the same. I wish to reiterate my comments on their activities, I made five years ago in this August forum and wish to place our sincere gratitude on record for their help in providing primary and tertiary care in some areas at least relieving the burden, on the depleted facilities available.

Acute Trauma and Rehabilitation

Summary of a paper to be presented

by

Dr. (Mrs) Senkamalam Theivendran

MBBS (Cey), D.A. (London)
(Hony Treasurer, Jaipur Foot Programme - Jaffna,
Anaesthetist, Government Teaching Hospital - Jaffna, Sri Lanka)

This paper describes the problem of loss of limbs in the North of Sri Lanka. During the period of 1987 -93 884 amputees were fitted with prosthesis. The cause of limb loss was mainly due to bomb blast and injuries by pressure mines (649) while accidents (75) and diabetic complications (77) were also common.

The needs of the amputees for prosthesis was mainly met because of the Jaipur Foot Programme whose ideal is **"They shall not suffer"**. This programme started by the voluntary non-governmental agencies employ technology and methods appropriate for local conditions. The care is taken to facilitate the practice of local customs such as squatting on the ground and sitting cross legged etc. Rehabilitation services have also provided after prosthetic fitting including co-ordination with the Jaffna Hospital and hostel facilities for those who come from a distance. Physiotherapy, guidance and counseling services are also provided.

Many NGOs have assisted us in funding this project. These include NORAD, DIAKONIA, SCF (UK) and the World Council of Churches. However funding is still short and at this time 150 amputees are on the waiting list.

INTERNATIONAL CONFERENCE ON HEALTH

VICTIMS OF WAR IN SRI LANKA: A Quest for Health Consensus

Health of refugees

by

J. De Vries

Department of Psychology, Tilburg University, The Netherlands

Subjects

Fifty-one Sri Lankan refugees (28 women; age range: 16-67), of which 47 were living in different refugee camps in Tamil Nadu, South India.

Measures

Each respondent filled in four questionnaires. Furthermore, they were interviewed. The questions in the interview were mainly concerned with problems within the camps, the reason for leaving Sri Lanka, social support, and emotions.

The questionnaires used were the Hopkins Symptom Checklist-58 (HSCL-58; Derogatis, Lipman, Rickles, Uhlenhuth, & Covi, 1974) which is a measure of (mental) health; the Life Orientation Test (LOT; Scheier & Carver, 1985) which measures optimism/ pessimism; the COPE (Carver, Scheier & Weintraub, 1989; Fontaine, Manstead, & Wagner, 1993), a questionnaire measuring coping styles, and the Mullidimensional Health Locus of Control scale Form A (MHLC-A; Wallston, Wallston, & DeVellis, 1978). The latter questionnaire exams which of three attribution styles a person uses in order to explain his/her health state. Finally, a post-traumatic stress disorder (PTSD) scale was constructed on the basis of subscales of some of the above mentioned questionnaires.

Results

More than ten per cent of the respondents scored moderately to extremely on somatization. In addition, 15.8 per cent scored high on depression, while nearly 20 per cent indicated to be anxious. Especially the use of particular coping styles appeared to predict a bad mental health state.

There also appeared to be a relationship between personal loss (other than material loss) or traumatic experiences (e.g., witnessing the killing of a family member) and mental health.

There are indications that 12 per cent of the respondents suffer from PTSD. For instance, more than one-third of the refugees said that they had bad dreams with scores ranging from 'moderately' to 'extremely'.

An internal health locus of control predicted, in part, respondents' scores on depression.

Concerning the refugee camps, a large number of problems were mentioned in the area of physical health, psychological health, social relationships, environment, and level of independence.

INTERNATIONAL CONFERENCE ON HEALTH

VICTIMS OF WAR IN SRI LANKA: A Quest for Health Consensus

Workshop: Repatriation: Realities and Expectations

Ms. Helena J. Whall
Researcher, Tamil Information Centre

Whilst the war in Sri Lanka has affected all of the ethnic communities in the island, the majority of persons who have been displaced, both externally and internally, are the Tamils. It is their expectations of repatriation and their actual experience of repatriation that this paper will therefore focus upon.

Tamils have been displaced from their homes of origin in various waves since the early post-independence period. This paper will trace these different phases of displacement and examine the displaced Tamils' relative expectations and experiences of repatriation. It will reveal that for all of the displaced Tamils, the prospect of repatriation enshrines two expectations, firstly, that they will be able to return to their original homes of origin and secondly, that they will be able to return in safety and dignity. Indeed, these are the two conditions which under-pin the principle of repatriation under international refugee law. This paper will reveal, however, that despite the convergence of the displaced Tamils' expectations of repatriation and the international communities' commitment to fulfil these expectations, the repatriation of displaced Tamils from South India, from Europe and North America and within Sri Lanka, often falls short of providing displaced Tamils with a safe return to their homes of origin.

In order to illustrate this, this paper will examine to what extent the failure of the repatriation programme initiated under the 1987 Indo-Sri Lanka Accord was due to the lack of consideration given to the Tamils' right to return to their home of origin in safety nd dignity. Similarly, it will examine to what extent Switzerland's decision in January 1994, to deport rejected Tamil asylum-seekers to Sri Lanka, will affect the Tamils' right to return to their home of origin in safety and dignity. It will also analyse to what extent The Asylum and Immigration Act, July 1993, has affected the UK Tamils' right to return to their homes of origin in safety and dignity. Lastly, this paper will attempt to reveal that despite the commitment of the international donor community, India, Sri Lanka and the UNHCR since the outbreak of war in 1990, to preventing internally displaced persons in Sri Lanka from seeking refuge in India or abroad, to providing protection and humanitarian assistance to the displaced in welfare centres across the island and to resettling them in their homes of origin in safety and dignity, the displaced Tamils regularly find themselves expendable to the expedient political imperatives of the LTTE and the Sri Lankan government, as they both continue to battle over the control of contested territory.

This paper will conclude by recommending that the application of some principles of international refugee law and armed conflict law might go some way towards ensuring that displaced Tamils are able to return to their homes of origin in safety and dignity.

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